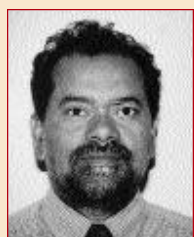


MAIN TOPIC

Managing the somatoform disorders

A fascinating group of conditions that have recently emerged from a period of relative disregard and neglect.



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The somatoform disorders are characterised by the presence of physical symptoms in the absence of a diagnosable medical illness to account fully for them. The symptoms are presumed to be psychologically based, outside the patient's conscious control, and should be severe enough to cause significant distress, or impair interpersonal, social and occupational functioning. Patients presenting with somatoform symptoms are seen in a variety of medical settings and are often a source of frustration because of their incessant visits and resistance to reassurance. Despite their relatively small numbers they are liable to consume a disproportionately large share of the available health resources because of excessive consultations, special investigations and treatment. This imposes an important responsibility on doctors, particularly at primary care level, to identify and manage these patients appropriately and timeously.

These are a fascinating group of conditions that have recently emerged from a period of relative disregard and neglect. Interest has been aroused by research findings in fields such as psychoneuroimmunology, invoking a reconceptualisation of conventional notions of health and disease, and a re-exploration of the mind-body divide.

Historically, the status of these disorders has often been controversial and illustrates the powerful role of historical epoch and culture in shaping the expression of emotional distress. The current preoccupation with health and the perfect appearance, and the arrival of indeterminate conditions such as chronic fatigue syndrome and Gulf War syndrome, illustrate this.

The differentiation between physical illness and psychogenic symptoms, while being problematic philosophically because of its inherently dualistic orientation, remains limited by currently available scientific evidence. The somatoform disorders have achieved a degree of legitimacy by their inclusion in current psychiatric disease classifications. This is not without problems, demonstrated by the unfortunate attachment of stigma and other social disadvantages that psychiatric diagnoses often attract (somatisers are not very popular people!).

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CLASSIFICATION

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, the American Psychiatric Association's catalogue of mental disorders, designates five specific somatoform disorders.

- somatisation disorder
- conversion disorder
- hypochondriasis
- body dysmorphic disorder
- pain disorder.

There are also two residual categories, namely undifferentiated somatoform dis-

order and somatoform disorder not otherwise specified, to accommodate symptoms that do not meet the criteria for the specific somatoform disorder diagnoses.

Somatisation disorder is characterised by a variety of symptoms in multiple organ systems, usually a combination of pain, gastrointestinal, sexual and pseudoneurological symptoms. It differs from the other somatoform disorders by this multiplicity of complaints and the multiple organ systems involved. The disorder is chronic, with onset before 30 years of age, and is associated with significant psychological distress, psychosocial dysfunction and excessive help-seeking behaviour. Patients often have poor social support and generally require social grants. There is a strong association with co-morbid psychiatric problems including depression, cluster-B personality disorder (histrionic and borderline), and eating disorders. There may be a history of childhood sexual abuse and complex post-traumatic stress disorder (PTSD). The management of these patients is often complicated by difficulties in the doctor-patient relationship, repeated acting-out behaviours such as parasuicide and deliberate self-harm, and substance abuse.

Conversion disorder is defined by the presence of one or more neurological symptoms (e.g. paralysis, blindness, seizures, or numbness) that cannot be accounted for by a diagnosable neurological or medical disorder. Physical examination may reveal unanatomical physical signs, and special investigation results are usually negative. The relationship between the physical symptom and the underlying psychological conflict may be strikingly clear (e.g. paralysis in a soldier facing battle). Conversion symptoms, which are significantly more common in women than

men, may be a manifestation of childhood sexual abuse. They may also be the presenting problem in the index patient in a dysfunctional family, often distracting the family and the treating doctor from more significant problems such as domestic violence, sexual abuse or alcoholism. It is important to remember that conversion symptoms can occur in patients with established neurological disease (i.e. pseudoseizures in an epileptic). Similarly, a significant number of patients diagnosed with conversion symptoms will eventually receive an actual disease diagnosis. Bias towards women within medical systems and towards patients from diverse cultural or deprived backgrounds needs to be guarded against to prevent premature diagnosis of conversion disorders in the presence of actual disease.

It may be necessary to clarify the limits of the interventions on offer, and appointments may have to be scheduled strictly.

Hypochondriasis, the commonest of the somatoform disorders, is defined by the presence of a preoccupation with fears of having a serious disease based upon the misinterpretation of one or more physical symptoms. Hypochondriacs are less concerned with their symptoms *per se* than they are with what their symptoms signify. They often display an obsessive preoccupation with their bodies and harbour the conviction that they are afflicted with a serious disease. They visit their doctors repeatedly, present their complaints in a detailed and ruminative manner

(in contrast to the histrionic style seen in somatisation disorder), and defy the reassurances offered by negative examinations and special investigations. Men and women are affected in equal numbers and there may be a strong family history of hypochondriasis. Patients' illness concerns result in significant distress to themselves, their loved ones, and (not least) their treating doctors.

Body dysmorphic disorder is characterised by a preoccupation with an imagined anatomical defect (e.g. a large nose) or an exaggerated distortion of a minor defect in physical appearance (e.g. mild acne). Despite its apparent triviality, the condition may be severely stressful for patients, who may be virtually incapacitated by social avoidance and emotional distress. Cultural shaping may play a significant role in the generation of these concerns by the high premium placed on physical appearance in some societies. Patients are inclined to avoid mirrors or scrutiny through social exchanges and will often procure repeated plastic surgical procedures. There seems to be a correlation with obsessive-compulsive disorder in terms of some of the clinical features and the underlying biological substrate, which is supported by a shared response to certain anti-obsessional psychotropic drugs.

Pain disorder is similar to a conversion disorder in which pain is the presenting complaint. The underlying cause must be at least partially psychogenic, and the condition should be accompanied by a degree of emotional and functional impairment. There may be an associated physical condition, but the pain is out of proportion to its extent or severity. Pain disorder is diagnosed twice as frequently in women as in men, and there may be a positive family history. Many

chronic pain specialists find the notion of somatoform pain problematical. There are inherent difficulties in trying to discriminate physically based pain from psychogenic pain, and the somatising aspect of the diagnosis may lead to a tendency to underestimate the patient's subjective pain experience. The stigmatising effect of acquiring a psychiatric diagnosis may also be uncomfortable for patients.

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MANAGEMENT

The management of the somatoform disorders is widely regarded as complex and challenging, and is often shrouded in a pall of pessimism and despair. This view is justified to some extent by the frequent chronicity and tenacity of somatoform symptoms. However, this should not obscure the fact that some fairly straightforward interventions can offer dramatic results, particularly if offered timeously, before the symptoms and accompanying pathological illness behaviours become entrenched. Many of these interventions can be (and often have to be) administered at the primary care level. Specialist assessment may be necessary in complex cases, especially in the presence of co-morbid psychiatric disorders or substance abuse.

It is useful to organise the assessment and management approach around a series of discrete steps.

The initial evaluation of somatic symptoms should always be directed at **excluding an underlying physical illness**. It may be difficult to determine how far to proceed in the face of negative results, especially when patients refuse to be reassured by these. The nagging possibility that an occult medical condition could emerge later may engender doubt and anxiety.

When it becomes apparent that the physical symptoms are psychogenic in origin, a complete **psychiatric assessment** is required. A specific somatoform disorder diagnosis is made according to a standard system of classification, for example, the *DSM-IV*, including an assessment of the duration, severity and psychosocial impact of the symptoms. Somatic symptoms may accompany a range of psychiatric disorders, including depression, anxiety disorders, schizophrenia, and substance use disorders (which masquerade as vague physical symptoms for which patients repeatedly seek medical attention). The **identification of co-morbid psychiatric conditions** may have very important treatment and prognostic implications.

A crucial next step is the formulation of a **biopsychosocial understanding** of the patient and his/her symptoms. This would address matters such as familial and temperamental vulnerabilities; the symbolic meaning the patient ascribes to the symptoms and how this connects with formative and current life experiences; the influence of stressful life circumstances; the role of learning, especially as it applies to the reinforcement of pathological illness behaviour; and the broader overarching influence of the social and cultural context.

These assessments will determine the choice of a **definitive treatment** strategy for the individual patient.

A central feature of that definitive treatment strategy is the **doctor-patient relationship**. It has been demonstrated repeatedly that the most helpful intervention for many patients with somatoform disorders is a stable, ongoing relationship with a caring, reassuring and supportive doctor who can empathetically understand and validate their physical and emotional distress. The ideal doctor would have great skills not only at mediating patients' inner conflicts, but also in dealing with his 'own stuff'. He should be undogmatic, open-minded and able to cope with uncertainty when confronted with a condition where the physical and psychological bases are unclear. Conflicts between empathy and apathy, underinvolvement and overinvolvement, undertreatment and overtreatment, and a range of other emotional responses including frustration, anger, resentment and despair may need to be managed appropriately, for example in doctor support groups. Patients often make unreasonable demands with regard to the frequency and extent of treatment. It may be necessary to clarify the limits of the interventions on offer, and appointments may have to be scheduled strictly.

Because of the invariable impact on social functioning, it may be useful to offer couple or family interventions, and the assistance of a social worker and other members of a multidisciplinary team (i.e. psychologists and occupational therapists) could prove helpful.

Psychopharmacological treatments are used most commonly in patients who have co-morbid psychiatric conditions, and the somatoform symptoms may resolve with

successful treatment. The selective serotonin reuptake inhibitors (SSRIs) have shown some success, especially in somatoform disorders characterised by obsessional features, such as hypochondriasis and body dysmorphic disorder.

Cognitive behaviour therapy, which can be delivered in individual or group settings, has also shown a range of benefits with regard to symptom reduction and enhancing overall sense of well-being.

It is not unusual for legal and ethical issues to arise in the management of these patients, given the range of difficulties already mentioned. The legal matters usually revolve around confidentiality and access to patient information. Ethical issues may arise in the context of emotional conflict between the doctor and the patient or by desperation and frustration often experienced by both. This may take many forms, for example the temptation to administer treatment without full disclosure of its purpose or mode of action (i.e. a placebo), deliberately overtreating a trivial condition and exposing the patient to iatrogenic hazards, and colluding in other ways with patients' pathological illness behaviours for perverse gain. These are common pitfalls that ought to be guarded against by constant vigilance and the highest ethical standards at all times.

CONCLUSION

Patients who somatise their emotional difficulties are seen in many medical settings. They are relatively small in number, but can potential-

ly consume a large portion of the available health resources. They resist reassurance and are often in conflict with their doctors, with invariable professional, ethical and legal implications. Prompt management promises the best outcome. This imposes an important responsibility on primary care practitioners to screen and manage these patients appropriately.

Conceptually, these disorders operate in the exciting and burgeoning field of psychosomatic medicine in which fascinating research findings are emerging. They invite a re-exploration of the boundaries of mind-body medicine, and a reconsideration of the social and cultural determinants of health and disease.

FURTHER READING

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IN A NUTSHELL

Somatoform disorders are characterised by physical symptoms in the absence of a diagnosable medical condition.

Somatoform disorders are classified in the *DSM-IV* into five specific types: somatisation disorder, conversion disorder, hypochondriasis, body dysmorphic disorder, pain disorder.

Somatisation disorder exhibits a combination of multiple organ symptoms, involving pain, gastrointestinal, sexual and pseudoneurological symptoms.

Conversion disorder is defined by the presence of one or more neurological symptoms, e.g. blindness, paralysis, seizures or numbness.

Hypochondriasis is defined by the presence of a preoccupation with fears of having a serious disease. Physical symptoms are misinterpreted.

Body dysmorphic disorder is characterised by a preoccupation with an imagined anatomical defect such as a large nose, or an exaggeration of a minor appearance defect.

Pain disorder is similar to conversion disorder, with pain being the presenting complaint.

Management should be prompt, with a thorough assessment, initially directed at excluding an underlying physical illness.

A complete psychiatric assessment may be required, and identification of co-morbid psychiatric conditions may have significant implications regarding treatment and prognosis.

The doctor-patient relationship may suffer or be severely strained.

Psychopharmacological treatments and/or cognitive behaviour therapy may be indicated.